MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-021847

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4927

FILED MAY 17 1963

DO NOT WRITE ON THIS STUB — AMENDED

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

DOCUMENT

USE BLACK INK OR TYPEWRITER RIBBON

RIDZON

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST.LOUIS,MO.
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: ST.LOUIS CITY HOSP.#.1
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St.Louis
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 5824 Pine St.
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Joseph; Middle; Last: Ladendecker

4. DATE OF DEATH: Month: 5; Day: 5; Year: 63

5. SEX: Male

6. COLOR OR RACE: White

7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 10-8-1883

9. AGE (last birthday): 79
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HR: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: General

11. BIRTHPLACE (City and state or country): Illinois

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Casper Ladendecker

13b. MOTHER'S MAIDEN NAME: Mary Foust

14. NAME OF HUSBAND OR WIFE: None

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of s
no
O.

17. INFORMANT: Wm.Ladendecker
Address: 6406 Myrtle Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Staphlococcal Septicemia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Paralytic ileus - Drug induced
DUE TO (c): 292.4
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.
☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 4-29-63 to 5-5-63 and last saw her him alive on 5-5-63
Death occurred at 4:15 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Thomas J Ridzon (Degree or title) M.D.

22b. ADDRESS: 1515 Lafayette ave

22c. DATE SIGNED: 5-5-63

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 5-7-63

23c. NAME OF CEMETERY OR CREMATORY: Todd Mills Cemetery

23d. LOCATION (City, town, or county) (State): Pinckneyville,Ill.

24. FUNERAL DIRECTOR ADDRESS: J.W.Clark F.Home 1125 Hodiamont

25. DATE RECD. BY LOCAL REG.: MAY 7 1963

26. REGISTRAR'S SIGNATURE: Hoard Smith . M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed [signature]

Licensed Embalmer No. 4544

P.O. Address St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.